WELCOME!

Congratulations!

he hardest step with counseling is making the first appointment and you did it! Here re a few recommendations to keep your momentum so you can maximize your enefits from coaching or counseling:

inancial Concerns: If there are any financial issues or concerns we may be able to ork with you on this.

alendar: Always remember to have your calendar when you come to TLC and when ou call to reschedule:

ave time: Having your calendar will save you time and keep you from needing to emember to call us back

ife gets busy: Often people forget to call back to reschedule or schedule a follow-up ppointment

onsistency: Follow-up appointments are important in order to receive the maximum enefits from your first session!

anceling or rescheduling: If you do not receive a reminder call please keep in mind he reminder is a courtesy but we need to leave it up to you to contact us at least two) business day prior to your appointment time if you need to reschedule

xpectations: Everyone has their own idea of what to expect from counseling varying om watching Dr. Phil or prior experiences. Please discuss your feelings if you feel our expectations are not being met. We can usually address this concern right away.

losure: When things are going well often clients cancel their appointment before tting us know about their progress. We love to hear the good news so it's very nportant to have that final session to celebrate your counselor!

Directions:
For directions to our location, please download the maps at totallifecouseling.com/maps

Bring Forms:
Please remember to print out your new client registration forms and fill them out prior to your first session. Download the forms @ totallifecounseling.com/forms

Should you need further assistance or an emergency arises before we can meet, please feel free to call 407-248-0030

STRESSLESS
STRESSLESS EDUCATIONAL SERIES
StressLessSeries.com

TOTAL LIFE COUNSELING
TotalLifeCounseling.com

407.248.0030 Info@TotalLifeCounseling.com Total Life Main Office, 1507 S. Hiawassee Road, Suite #101, Orlando, FL 32835

Individual, Family, Marriage & Group Counseling
P: 407-248-0030
F: 407-248-0226
Satellite Locations:
East Orlando, Clermont, Winter Park & Lake Mary

GENERAL INFORMATION

Date: _____ How did you hear about us? _____ May we send a thank you gift? _____

Full Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. _____

Nick Name:_____ Name You Prefer: _____

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____

Parent/Guardian: _____ Relationship: _____

CONTACT INFORMATION

Street Address: _____ Suite/Apartment Number: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Mailing Address or Post Office Box: _____

City: _____ State: _____ Zip Code: _____ May We Send Mail Here: ☐ Yes ☐ No

Home Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Mobile Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Work Phone: (_____) _____ May We Leave a Message Here: ☐ Yes ☐ No

Email Address: _____ May We Send Email Here: ☐ Yes ☐ No

I would like to be added to Total Life Counseling Newsletter to receive free articles, tips and resources: ☐ Yes ☐ No

I prefer to be ☐ texted ☐ emailed ☐ phone call ☐ none for appointment reminders.

EMERGENCY CONTACT

Name: _____ Relationship: _____

Home Phone: (_____) _____ Mobile Phone: (_____) _____

EMPLOYMENT INFORMATION

Employer: _____ Length of Employment: _____

Occupation: _____ Average Hours Worked Per Week: _____

Average Annual Salary: ☐ $0 to $10,000 ☐ $10,001 to $20,000 ☐ $20,001 to $40,000 ☐ $40,001 to $50,000 ☐ $50,001 to $60,000 ☐ $60,001 to $80,000 ☐ $80,001 to $100,000 ☐ More than $100,000

EDUCATION INFORMATION

Last Year of School Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

Are You Currently in School: ☐ Yes ☐ No. If Yes, What School: _____

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RELATIONAL INFORMATION

Current Relational Status: ☐ Single ☐ Dating ☐ Engaged ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Are You Content with Your Current Status: ☐ Yes ☐ No. If No, Briefly Explain: _____

If Married, How Long: _____ Number of Previous Marriages for You: _____ For Your Partner: _____

If Separated or Divorced, How Long: _____ If Widowed, How Long: _____

Partner's Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Rev. _____

How Long Have You Known Your Partner: _____ Age: _____ Preferred Name: _____

Partner's Race: ☐ White ☐ Black ☐Hispanic ☐ Asian ☐ Other: _____ Partner's Sex: ☐ Male ☐ Female

Partner's Occupation: _____ Average Hours Worked Per Week: _____

Last Year of School Partner Completed: ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED College: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Other: _____

What Words Would You Use to Describe Your Partner: _____

Is Your Partner Supportive of You Seeking Counseling: ☐ Yes ☐ No ☐ Unsure ☐ Partner Doesn't Know

With Whom Do You Currently Live (*Check All that Apply*): ☐ Alone ☐ Spouse ☐ Children ☐ Parent(s) ☐ Sibling(s)
☐ Boyfriend ☐ Girlfriend ☐ Roommate ☐ Other: _____

CHILDREN

List Your Children (Living or Deceased):

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Biological, Adopted, Step)*	Living with You?	Describe Him/Her

Have You Ever Placed a Child for Adoption: ☐ Yes ☐ No. If Yes, When: _____

Have You Ever Had a Miscarriage or Medical Abortion: ☐ Yes ☐ No. If Yes, When: _____

FAMILY OF ORIGIN

List Mother, Father, Brothers, Sisters, Step Family, and Any Other Family Members who Effected You Positively or Negatively:

Name	Sex	Current Age or Year of Death	Relationship to You *(e.g. Mom, Dad, Sibling,Step)*	Occupation	Describe Him/Her

Do You Have a Personal Support System: ☐ Yes ☐ No. If Yes, Who: _____

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MEDICAL INFORMATION

Primary Physician: _____ Phone: (_____) _____

Address: _____ City: _____ Zip: _____

Specialty *(e.g. Family Practice, OB/GYN, Internal Medicine)*: _____

Are You Currently Receiving Medical Treatment: ☐ Yes ☐ No. If Yes, Please Specify: _____

List Any Conditions, Illnesses, Surgeries, Hospitalizations, Traumas or Related Treatments You Have Had *(Use Back if Necessary)*: _____

_____

MEDICATIONS

List All Current Medications You Are Taking, Including those You Seldom Use or Take Only as Needed (Use Back if Necessary):

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Medication: _____ Dosage: _____ ☐ Improves ☐ Prevents ☐ Controls: _____

Are You Taking these Medication(s) According to Your Doctor's Recommendations: ☐ Yes ☐ No

If No, Briefly Explain: _____

PHYSIOLOGICAL SYMPTOMS

Please Check Any of the Following Physiological Symptoms/Sensations that Apply to You Presently, or in the Recent Past:

Headaches.....	☐ Past	☐ Present	Dizziness.....	☐ Past	☐ Present	Stomach Trouble....	☐ Past	☐ Present
Visual Trouble.....	☐ Past	☐ Present	Sleep Trouble.....	☐ Past	☐ Present	Trouble Relaxing....	☐ Past	☐ Present
Weakness.....	☐ Past	☐ Present	Tension.....	☐ Past	☐ Present	Rapid Heart Rate...	☐ Past	☐ Present
Difficulty Breathing..	☐ Past	☐ Present	Intestinal Trouble....	☐ Past	☐ Present	Hearing Noises.....	☐ Past	☐ Present
Change in Appetite.	☐ Past	☐ Present	Tiredness.....	☐ Past	☐ Present	Pain.....	☐ Past	☐ Present
Hearing Voices.....	☐ Past	☐ Present	Seeing Things.....	☐ Past	☐ Present	Other.....	☐ Past	☐ Present

Your Height: _____ Your Weight: _____ How has Your Weight Change in the Last 2-3 Months: _____

CURRENT STATUS

Please Check Any of the Following Problems which Pertain to You and/or Your Family:

Stress.....	☐ Past	☐ Present	Nervousness.....	☐ Past	☐ Present	Anxiety.....	☐ Past	☐ Present
Panic.....	☐ Past	☐ Present	Unhappiness.....	☐ Past	☐ Present	Depression.....	☐ Past	☐ Present
Guilt.....	☐ Past	☐ Present	Apathy.....	☐ Past	☐ Present	Terminal Illness.....	☐ Past	☐ Present
Recent Death.....	☐ Past	☐ Present	Grief.....	☐ Past	☐ Present	Hopelessness.....	☐ Past	☐ Present
Inferiority Feelings..	☐ Past	☐ Present	Defective Feelings..	☐ Past	☐ Present	Loneliness.....	☐ Past	☐ Present
Shyness.....	☐ Past	☐ Present	Fears.....	☐ Past	☐ Present	Friends.....	☐ Past	☐ Present
Marriage.....	☐ Past	☐ Present	Communication.....	☐ Past	☐ Present	Physical Abuse.....	☐ Past	☐ Present
Emotional Abuse....	☐ Past	☐ Present	Verbal Abuse.....	☐ Past	☐ Present	Sexual Abuse.....	☐ Past	☐ Present
Temper.....	☐ Past	☐ Present	Anger.....	☐ Past	☐ Present	Aggressiveness.....	☐ Past	☐ Present
Bad Dreams.....	☐ Past	☐ Present	Concentration.....	☐ Past	☐ Present	Racing Thoughts....	☐ Past	☐ Present
Unwanted Thoughts	☐ Past	☐ Present	Memory.....	☐ Past	☐ Present	Loss of Control.....	☐ Past	☐ Present
Impulsive Behavior.	☐ Past	☐ Present	Self-Control.....	☐ Past	☐ Present	Compulsivity.....	☐ Past	☐ Present
Sexual Problems....	☐ Past	☐ Present	Pregnancy.....	☐ Past	☐ Present	Abortion.....	☐ Past	☐ Present
Legal Matters.....	☐ Past	☐ Present	Trauma.....	☐ Past	☐ Present	Eating Problems....	☐ Past	☐ Present
Drug Use.....	☐ Past	☐ Present	Alcohol Use.....	☐ Past	☐ Present	Trouble with Job.....	☐ Past	☐ Present
Career Choices.....	☐ Past	☐ Present	Ambition.....	☐ Past	☐ Present	Making Decisions...	☐ Past	☐ Present
Children.....	☐ Past	☐ Present	Being a Parent.....	☐ Past	☐ Present	Finances.....	☐ Past	☐ Present
Recent Loss.....	☐ Past	☐ Present	Disaster.....	☐ Past	☐ Present	Smoke Cigarettes...	☐ Past	☐ Present

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LEVEL OF DISTRESS

Indicate How Distressed You Are by Placing an "X" on the Scale Below *(1 = Very Little Distress; 10 = Extreme Distress)*:

1 2 3 4 5 6 7 8 9 10

Are You Currently Experiencing Any Suicidal Thoughts: ☐ Yes ☐ No. Have You Experienced Them in the Past: ☐ Yes ☐ No

Have You Ever Attempted Suicide: ☐ Yes ☐ No. If Yes, When and How: _____

Have Any of Your Friends or Family Ever Committed or Attempted Suicide: ☐ Yes ☐ No

If Yes, When and Who: _____

PRESENTING ISSUES AND GOALS

Please Describe Why You Are Coming to Counseling *(i.e. What Are Your Issues, Problems?):* _____

_____

Why Have You Decided to Come for Counseling Now: _____

_____

What Do You Hope to Gain or Change by Coming for Counseling: _____

_____

How Long Do You Believe Counseling Should Last: _____

PREVIOUS COUNSELING

List Any Previous Counseling, Psychiatric Treatment, or Residential/In-Patient Care You Have Received *(Use Back If Necessary):*

Therapist: _____ Location: _____ Dates: _____ Reason: _____

Therapist: _____ Location: _____ Dates: _____ Reason: _____

RELIGIOUS BACKGROUND

Please describe your religious involvement if any. Are there any special religious, cultural or ethnic considerations we should be aware of?

_____

ACTIVITIES, INTERESTS, & STRENGTHS

What do you do in your spare time? _____

What do you do well? _____

TERMS OF SERVICE

I hereby give Total Life Counseling Center permission to provide counseling services for the client mentioned above:

Signed: _____ Date: _____

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Victimization History

Abuse:

Physical:

Sexual:

Mental:

Neglect:

Domestic Violence:

Past C.P.S. Involvement:

Potentially Abusive Behavior:

Substance	Onset	Current	Highest	Most Recent	Tolerance/Withdrawal
Alcohol					
Marijuana					
Cocaine					
Depressants					
Amphetamines					
Hallucinogens					
Opiates					
Inhalants					
K2, Bath salts, spice					
Other					
Tobacco					
Caffeine					

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Authorization of Release Form

Our therapists may find it helpful to consult with your attorney, doctor, school, or applicable parties regarding treatment. In order to consult we need your authorization. If applicable, please complete on for each contact.

I, _____, hereby authorize Total Life Counseling Center,
1507 S. Hiawassee Road, Orlando, FL 32835 to:

_____ Release To _____ Release from _____ Exchange Written and/or Oral Communication

_____ Psychiatric _____ Medical _____ Family

_____ Psychological _____ Counseling _____ Appointments/Payments

from the records of: _____ _____
Name of Client Date of Birth

To: _____

_____

Phone #/Email: _____

For the purpose of: ☐ Outpatient Counseling ☐ Coordination with schools
☐ Coordination with MD/Psychologist/OT Therapist/Therapist
☐ Coordination with other family members

I understand that under state and federal confidentiality provisions only the above specified information can be released to only the above specified person or agency. I also understand that I may revoke this release of information at any time, providing that I notify the authorized agency in writing to this effect, but that revocation has no effect on action previously taken.

This consent will expire on _____

_____
Client, Parent, Guardian Date

_____
Witness Date

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Financial Policy

Payment & Fee Policy:

We are committed to providing you with the best possible care. Payment for services is due at the time of service. We accept cash, checks, Master Card, and Visa. Our fees:

- Individual, Family and Marriage Sessions intake is _____ per hour, follow up sessions are_____ per hour, or if paid by cash or check _____ per hour ($5 per hour cash or check discount) effective September 1st, 2012.
- Payment methods: Checks and cash must be received before the session if sent via mail. If payment has not been received, the session must be rescheduled.
- Counselor Administrative Services: Treatment Summary Requests, Professional Letters, and Phone/Conference calls will be billed, if requested, at the individual therapeutic rate for a minimum of 30 minutes.
- Court Appearances and Depositions are billed by the hour, this would include the counselor's travel time and the amount of time the counselor is obligated to be away from our office. The hourly rate for a court appearance is double the hourly rate of that counselor. Payment is to be paid in advance, to be used as a retainer. Any unused funds will be refunded to the client.
- A cancellation fee is charged for appointments with **credit/debit** only that are no show or canceled without **2-business days** advance notice unless there is an emergency or illness. The no–show fee is equivalent to your normal session fee.
- Returned checks are subject to a $42 fee
- If a patient's appointments are being covered by PIP, we must have a credit card on file in the event that your claims are denied or benefits are exhausted. Please note that any charges not covered by the third party will be the patient's responsibility.

Disclosure:

Please be aware if for any reason we do not receive payment, your information may be used during a debt collection.

For your convenience, and to secure future appointments, please enter credit card information below. I authorize TLC to place my credit card information on file to charge for any applicable/outstanding fees.

(Optional) CC# _____ Exp: _____ CVC: _____

Policy on Insurance Reimbursement:

If you have medical Insurance that provides coverage for mental health counseling, we want to help you receive your maximum allowable benefits. We will be happy to help you process your insurance claim form for your reimbursement. A completed insurance form must accompany any such request at each visit. You are responsible for mailing it to the insurance company and tracking your reimbursement. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.
2. Our fees are generally considered to fall within the acceptable range by most companies, called "Usual, Customary and Reasonable" (UCR).
   Some companies pay a percentage of the UCR for a given area. However, some companies reimburse based on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. If your company requests a report from us in order to process your claim, we will need to receive our normal hourly fee from you for this service.
5. I am financially responsible for this treatment and for any portion of the fees not reimbursed or covered by my health insurance.

By signing below I agree to the terms listed above.

Signature _____ Date _____

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Please do not write in space below. For office use only

Issues	Descriptions & Objectives	Interventions

Diagnostic Impressions:

Axis I: _____

_____

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Informed Consent & Release of Liability

Name: (please print): _____

I understand the following:

1. Counseling services are provided by practitioners who have earned a Master's Degree, or higher, in the field of counseling from an accredited graduate program and who have been licensed by the state of Florida as Mental Health Counselors, Registered Mental Health Counselor Interns (under the supervision of a License Mental Health Counselor Supervisor).
    a. **Licensed Mental Health Counselors:** Jim West, Jamie Barrett, Jada Jackson, Matthew Martin, & Mayeling Angelastro
    b. **Licensed Marriage & Family Therapist**: Dr. Leslie Hamilton & Lyris Stueber
    c. **Licensed Clinical Social Worker**: Dana West
    d. **Registered Mental Health Counselor Intern:** Anna Vita, Teresa Kovach, Stephanie Booth, Marilyn Card, & Jesse Ewing
    e. **School Psychologist:** Marilyn Card
    f. **Graduate Student Intern:** Shawn Gordon
        i. Graduate student who is earning a Master's Degree in the field of counseling from an accredited graduate program and who is supervised by Licensed Mental Health Counselors by the State of Florida.
2. Although I expect benefits from this treatment, such benefits or particular outcomes cannot be guaranteed.
3. Due to the counseling or therapy, I may experience emotional strains, feel worse during treatment, and make life changes that could be distressing.
4. This counselor is not providing an emergency service; therefore, at any time you become extremely emotionally distressed or are in danger of hurting yourself or someone else, please call 911 for assistance.
5. Regular attendance will produce maximum results, but I am free to discontinue treatment at any time. A final closure/summary session is highly recommended to get the greatest benefits.
6. I understand that my counseling records & conversations with the counselor are kept confidential, except where disclosure is required by law (i.e. abuse of a child, elderly or disable person; potential harm or threat to self or others and specific information subpoenaed by a court of law.)
7. I know of no reasons that I should not undertake this therapy and I agree to participate fully and voluntarily.

All group members agree if the therapist is sued for breach of confidentiality, the client who breached confidentiality will hold the therapist harmless from any damages including attorney fees. Consequences of breaching confidentiality may result in pressed charges by another client. Although confidentiality agreements have been signed by all group members, this does not guarantee that confidentiality will not be breached by fellow group members.

My signature below indicated that I grant informed consent for Total Life Counseling to provide counseling services to myself and or minor members of my family.

Signature: _____ Date:_____

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Notice of Privacy Practices

This Notice Describes how medical information about you may be used and disclosed and how you can get access to this information about you may be used and disclosed and how you can get access to this information. Please review this document carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information (protected health information) used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment, and health care operations.

• *Treatment* means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of treatment would include psychotherapy, medication management, etc.

• *Payment* means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be billing your insurance company for your services.

• *Health Care Operations* include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would include a periodic assessment of our documentation protocols, etc.

In addition, your confidential information may be used to remind you of an appointment (by phone or mail) or provide you with information about treatment options or other health-related services. We will use and disclose your PROTECTED HEALTH INFORMATION when we are required to do so by federal, state or local law. We may disclose your PROTECTED HEALTH INFORMATION to public health authorities that are authorized by law to collect information; to a health oversight agency for activities authorized by law included but not limited to: response to a court or administrative order, if you are involved in a lawsuit or similar proceeding; response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested. We may release your PROTECTED HEALTH INFORMATION to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. We may use and disclose your PROTECTED HEALTH INFORMATION when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your PROTECTED HEALTH INFORMATION, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

• The right to request restrictions on certain uses and disclosures of PROTECTED HEALTH INFORMATION, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

• The right to request to receive confidential communications of PROTECTED HEALTH INFORMATION from us by alternative means or at alternative locations.

• The right to request an amendment to your PROTECTED HEALTH INFORMATION.

outside of treatment, payment and health care operations.

• The right to obtain a paper copy of this notice for us upon request.
We are required by law to maintain the privacy of your PROTECTED HEALTH INFORMATION and to provide you with notice of our legal duties and privacy practices with respect to PROTECED HEALTH INFORMATION.

We are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all PROTECTED HEALTH INFORMATION that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:
The Privacy Officer
Total Life Counseling
1507 S. Hiawassee Road #101
Orlando, FL 32835
(407) 248-0030

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877.696.6775 (toll-free)

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Acknowledgement of Receipt: Privacy Practice Notice

I,_____ have received a copy of Total Life Counseling Center Notice of Privacy Practices.

Street Address: _____

City: _____State:_____ Zip:_____

Client
Signed:_____ Date:_____

Witnessed
Signed: _____Date:_____

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DIRECTIONS

Greetings and thank you for contacting Total Life Counseling Center. We consider it a privilege to serve you and look forward to working with you. Below are instructions to our offices. You can also go to our website and click the Office Locations Link and click on the office you are attending. Then you can enter your address for directions.

Metro West Office @ Metro West Professional Plaza, 1507 S. Hiawassee Road Suite 101, Orlando FL 32835:

- **From Kissimmee N. on Turnpike to EXIT 259, Take I-4 toward Tampa to the Kirkman Rd Exit 75B and take Kirkman 2.6 miles. Take Left on Metro West Blvd for 1 mile. Take Right on Hiawassee Road .3 miles and turn between the McDonalds on the right and our Building. Then immediately turn right again into the parking lot behind the building.**
- **From Tampa I-4 East to Orlando and take the Kirkman Rd Exit 75B and take Kirkman 2.6 miles. Take Left on Metro West Blvd for 1 mile. Take Right on Hiawassee Road .3 miles and turn between the McDonalds on the right and our Building. Then immediately turn right again into the parking lot behind the building.**
- **Downtown Orlando/East Orlando: Take the 408 West to Hiawassee Road. Take Left on Hiawassee Road for 2 miles. Cross Raleigh Street and our building is past the McDonalds on the left. However, our parking lot access is behind the McDonalds. So after Raleigh Turn into the Winn Dixie Shopping Plaza and turn right between McDonalds & the Winn Dixie to access our parking lot behind the Building.**
- **From Clermont/Ocoee/Winter Garden/Oakland/Montverde: Take the 408 East to Hiawassee Road. Take Right on Hiawassee Road for 2 miles. Cross Raleigh Street and our building is past the McDonalds on the left. However, our parking lot access is behind the McDonalds. So after Raleigh Turn into the Winn Dixie Shopping Plaza and turn right between McDonalds & the Winn Dixie to access our parking lot behind the Building.**

Winter Park Office at 1950 Lee Road Suite 115, Winter Park, FL 32789:

- **From Kissimmee: Get on FL-528 W/FL-528 Toll W in Orange County from N John Young Pkwy. Take I-4 E to FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck in Fairview Shores. Take exit 88 from I-4 E. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park). Destination will be on right.**
- **From Tampa: Get on I-275 N from N Florida Ave. Follow I-4 E to FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck in Fairview Shores. Take exit 88 from I-4 E. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the right.**
- **Downtown Orlando/East Orlando: Take I-4 East toward Orlando/Downtown to Lee Road in Winter Park. Take Right on Lee Road EXIT 88. Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the right.**
- **From Daytona/Sanford/Lake Mary/Altamonte Spgs/Longwood: Take I-4 W toward Winter Park to Lee Road Exit 88. Take Left on Lee Road Use the right 2 lanes to turn right onto FL-423 N/Lee Rd/U.S 17 Truck/U.S 92 Truck (signs for Eatonville/Winter Park) Destination will be on the right.**

East Orlando Office – 1850 N Alafaya Trail #1A Orlando, FL 32826

- **From 408: Heading east, take the Alafaya trail exit. Head South on Alafaya Trail (SR 434) by taking a left. Cross E Colonial and it will be on the left hand side across from the race track/Bubbalous.**

Clermont Office-(Corner of Pearl St and Hwy 27) 100 N US Hwy 27 Unit B Minneola, FL 34715

- **From Winter Garden/Ocoee/Oakland: Take Colonial/Hwy 50 West through Clermont. Head North on 27 building next to Jacks barbecue (yellow building with green awning next to Jacks Barbecue in the rear). From Downtown Clermont Minneola or Groveland: Head North on 27 building next to Jacks barbecue. Yellow building with green awning next to Jacks Barbecue in the rear Park in rear of building. We are in the same building as the TV Repair next to Jack's Barbecue. Wait in the reception area until you are called.**

Lake Mary: 1325 South International Pkwy Suite 2221 Lake Mary, FL 32746

- **From I-4 East: Take exit 98 toward Lake Mary/Heathrow. Turn slight left onto W Lake Mary Blvd. Turn left onto S International Pky. Pass through 1 roundabout.**
- **From I-4 West: Take exit 98 toward Lake Mary/Heathrow. Turn right onto W Lake Mary Blvd. Take the 1st left onto S International Pky. Pass through 1 roundabout.**
- **Follow the roundabout until the Lake Mary Professional Complex (continue in roundabout past Oakmont Community sign.) The Lake Mary Professional Complex Parking lot is next to the Hyatt Place just before Walgreens. The office is located in building #1325 near the center of the complex. You may take the elevator or stairs to the second floor. Office #2221. You will see our TLC signs on a few of the windows, but the door reads Scott Martin Financial (we share their office). You may come into the yellow waiting room and have a seat and your counselor will come get you at your appointment time. If you have challenges finding the office please call the TLC main number at 407-248-0030.**

Referrals

Holistic Doctors

Dr. Donna Johnston
Healing Alternatives
(407)682-7111

Dr. Kirt Kalidas, MD – Holistic
The Center for Natural & Integrative Medicine
(407) 355-9246

Dr.Scott Vanlue. MD – Holistic
Everything Well

Family Physician & Dietician

Dr. Marissa Magsino
Metro West Internal Medicine
(407) 292-6778

Dr. Harding
(407) 671-0057

Allilin Family Medicine
(407) 657-2111

Dr. Rick Baxley
(407) 246-7001

Alice Baker, RD, LDN – Dietician
Joyful Nutrition
(407) 340-8251

Dr. Jennifer Bourst
Unity Family Chiropractic Center
(407) 460-0985

Vitamin Store

Vitamin Corner
(407) 656-1206

Clermont Herb Shoppe & Spa
(352) 243-3588

Family Law

Orlando

Diane N. Holmes – Attorney
N. Diane Holmes, PA, Family Law
(407) 843-1744

Tom Marks – Attorney
The Marks Law Firm – Family Law
(407) 872-3161

Rebecca Palmer – Attorney
Weiss Grunor & Barclay
115 E Marks St, Orlando
(407) 843-3990

Anthony Diaz – Attorney – Mediation & Collaborative Law
Law Office of Anthony J. Diaz
(407) 774-4949

Dr. Leslie Hamilton, PhD, LMFT – Parent Coordinator, Family Mediator & Collaborative Law
Total Life Counseling Center
(407) 248-0030

Aubrey Harry Ducker, Jr.
Attorney and Counselor at Law
407-645-3297

Andrea Pate
Pates Law Group
407-869-1166

Lake Mary

Elaine Silver
Collaborative Divorce lawyer
407-268-6830

Clermont

Jamie Barrett, LMHC, RPT-S – Parent Coordinator
Total Life Counseling Center
(407) 248-0030

Abigail Johnston
The Johnston Law Firm
(407) 514-2623

Joy Ragan
The Ragan Law Firm
(407) 447-5080

Boyette Cummins & Nailos– - Attorney
BCN Law Firm
(352) 394-2103

J.J. Dahl – Dahl Family Law Group
(352) 243-4100

OBGYN

Mark Bielawny
David Hazel-Ann Family Practice
407-381-7364

Dr. Joseph Kerpsack
352-241-7050

Dr.Andrew Karen
Southlake Hospital
352-241-7275

Occupational Therapist

Learn to Learn
(407)275-5550

Achieve Pediatric Therapy
(407) 277-5400

Personal Injury Attorneys

Wade Boyette
Boyett Offices
(352) 394-2103
Fax: (352) 394-2105

Umansky Law Firm
(407) 228-3838
Fax: (407) 228-9545

Psychiatrist

Dr. Heid Napolitano, MD
The Happy Mind Company
(407) 704-1461 – Southwest Orlando

Dr. Dhungana
Serenity Health
(352) 241-9282

Dr. Syed Quadri
(407) 270-7702

Dr. Morales
Child Psychiatrist – Oviedo
(407) 365-0440

Dr. Alvarez-Jacobs
Esperanza Behavioral Health
(407) 226-3733

Dr. Herndon Harding
(407) 671-0057 – Winter Park

Eating Disorder IOP

Blue Horizons, partnered with Remuda Ranch
(407) 719-6294

Eudine Harry MD
Center for Medical Weight Loss of Orlando
Medical Director
(407) 480-3339

Wekiva Springs Center
(Jackonville)
(904) 296-3533

Rega Mental Health Center
(Coral Springs)
(954) 346-8300

Renew Center of Florida (Boca Raton)
(954) 907-3446

Psychologist

William Steven, PhD –
Educational and Forensic Psychologist
Central Florida Psychological Consultants
609 West Montrose, Clermont, Florida 34711
(352) 365-2243

Dr. Charlene Messenger – Educational Psychologist
(407) 895-0540

Clarice L. Honeywell, M.S., NCSP – School/Educational
The Psychology & Counseling Group
(407) 523-1213

Dr. Patrick Gorman, DPSY, PSYD – Neuro- Developmental
(407) 644-7792

Marilyn Card
1507 S Hiawassee Rd Suite 101
Orlando, FL 32835
407-248-0030

Alex Sanchez, LLC- Biofeedback Therapist
(321) 289-6708
1612 Town Plaza Court
Winter Springs, FL 32708

Criminal Attorneys

Joe Pate – Attorney
Pates Law Group, P.A.
(407) 896-1166

Joy Ragan – Attorney
The Marks Law Firm – Family Law
(407) 872-3161

Zahra Umansky
Umasky Law Firm – Criminal & Juvenile
(407) 228-3838

Bill Umansky
(407) 599-3838

Anthony Diaz
(407) 774-4949

Residential Addictions

Central Florida Behavioral Hospital
(407) 370-0111

Center for Drug Free Living
(407) 245-0014

La Amistad Behavioral Health (Maitland)
(407) 647-0660

The Grove
(407) 327-1765

Seminole Mental Health
(407) 831-2411

Darryl Strawberry Recovery Center
(855) 973-7333

Inpatient for adults

Central Florida Behavioral
(407) 370-0111

La Amistad
(407) 647-0660

University Behavioral Center
(407) 281-7000

Seminole Community Mental Health
(407) 831-2411

Lakeside
(407) 291-6335

American Addictions Center
Ryan Aldrin
407-450-0947

Advanced Recovery Village
Kevin Reese
844-291-3568